Rutland Regional Medical Center
AN AFFILIATE OF RUTLAND REGIONAL HEALTH SERVICES

160 Allen Street
Rutland, VT 05701

802.775.7111

August 28, 2009

Beth Tanzman, Deputy Commission
Department of Mental Health
108 Cherry Street
PO Box 70
Burlington, VT 05402-0007

Dear Ms. Tanzman:

The Rutland Regional Medical Center is pleased to submit the attached bid proposal to replace a portion of the Vermont State Hospital.

Rutland Regional Medical Center strongly feels that we can play an important role in providing excellent care to these patients. There is certainly no financial reason for Rutland Regional to take on this task and these risks. We provide this proposal simply because it is the right thing to do for these patients.

We believe that this can be a sustainable model for the long term. In a professional career there are only a small number of opportunities to make a significant impact. This is one of those moments.

Sincerely,

Thomas W. Huebner
President

TWH:cn

Rutland Regional Medical Center
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160 Allen Street
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RUTLAND REGIONAL MEDICAL CENTER

Bid for Psychiatric Acute Care Services

To replace Vermont State Hospital

August 28, 2009

1. PROGRAM DESCRIPTION

The Rutland Regional Medical Center proposes to create and license a 28 bed inpatient psychiatric unit with three integrated milieus described below. This program is anticipated to have an average daily census (ADC) of 25. Rutland Regional's current program has an ADC of 12.5; the additional patients are now being served at the Vermont State Hospital. It is anticipated that the census at Waterbury would be reduced by 12.5.

It is important to note that although these patients are currently being served in two locations (Waterbury and Rutland), it is intended that the populations will be integrated and the level of service will be dictated by the needs of the patients. Said another way, there will not be "Rutland patients" and "State patients"; there will only be patients requiring an appropriate level of care. The clinical program is described in Section 3, below.

Rutland Regional and the Department reviewed the possibility of renovating space at Rutland Regional and found that it could not be done and meet patient needs and current code requirements. Consequently a new facility would have to be built, attached to Rutland Regional. The order of magnitude cost of this building is $25 million.

Various options for financing this facility have been considered. Neither Rutland Regional nor the State of Vermont believes they have the debt capacity to finance the construction of this building. Consequently Rutland Regional is proposing to create a new non-profit corporation (NewCo) to develop the building. NewCo will in turn lease the building to Rutland Regional utilizing a one year renewable lease structure. Rutland Regional will operate the program in the leased space under its license and provider number. Rutland Regional will be a specially designated hospital by the Department. It is hoped that this designation, as well as a contract with the State, will provide a sufficient revenue stream to ensure the operation of the program and to pay the rent to NewCo. Rutland Regional will transfer or lease the land and associated parking to NewCo with the requirement that the new building may only be used for inpatient psychiatry and if not will revert back to Rutland Regional. Upon maturity of the bonds, the bonds will revert to Rutland Regional.

NewCo will issue debt and build the building. It is anticipated that the bonds will be tax exempt variable rate demand bonds backed by a bank letter of credit. One element that requires testing is the willingness of lenders to provide financing to NewCo under this structure. They will need to feel confident that the revenue stream from the State will be sufficient to assure the debt can be repaid.

It is hoped that a CoN could be filed in mid 2010. If the CoN is approved by December 2010 construction could commence in spring of 2012 with occupancy in late 2013.

2. PROGRAM OF SPACE

Attached is the program of space developed by the Department's architect with Rutland Regional's input. This is for a 25 bed unit and will need to be expanded to 28 beds. The program elements of the space are largely accurate. The shape and relationships of the different program elements will need to be re-examined. The State and Rutland Regional determined that it would not be appropriate to refine this design until a workable financing option has been agreed upon. However, this draft plan was developed to support client-directed, trauma informed care. The cost estimate for this space in spring 2008 dollars was estimated to be $25 million.

3. PROGRAM DESCRIPTION AND STAFFING PLAN

The 28-bed inpatient psychiatric unit being proposed will provide services to three different levels of care within a single milieu. The levels of care will be organized into separate bedroom clusters, but will share much of the common space. The two lower levels of care (General and Secure) are comparable to the levels of care currently provided at Rutland Regional. The highest level of care (Intensive Care) is currently only provided at VSH and will represent a higher level of care then Rutland Regional has previously provided. The ICU will have an entirely separate treatment and dining spaces adjacent to the bedroom cluster. However, as ICU patients stabilize it is anticipated that they will increasingly take part in groups and activities outside of the ICU area until they are eventually transferred completely to a lower level of intensity. Likewise, patients may also progress during their stay from secure to a general level of care. Below is a brief description of each level of care.

General **Inpatient Unit** (8 Beds)

For patients who require who meet acute care criteria but whose level of immanent risk of harm to self or others is minimal. Patients on this unit typically demonstrate a high degree of behavioral stability and impulse control. It is anticipated that many of the patients on this level of care will be very close to meeting discharge criteria. Staffing within this level of care will maintain a minimum 7:1 patient to staff ratio. Common space for this level of care will have a fair amount of overlap with the Specialized level. All patients within this level of care will be voluntary.

A decision has not yet been made as to whether this unit would be locked or unlocked. A final determination will be dependent upon resolution of at least two issues. First, an architectural design that allows for safely sharing treatment and common space with the Specialized level of care will need to be developed. And second, we will need to have confidence that we can develop policies and procedures related to contraband, patient searches, and visitors that will ensure patient safety at a level that meets both best practice and regulatory (e.g., CMS, Joint Commission) standards.

Secure **Inpatient Psychiatric Services** (14 Beds)

Patients within the Secure level of care are generally those who are at high risk for harm to self or others, but have the ability to maintain safety with staff support. Staffing at this level of care will maintain a minimum of 6:1 patient to staff ratio with the ability to 1:1 as necessary. Patients in this area will likely be a mix of voluntary and involuntary patients.

Intensive **Care Unit** (6 Beds)

Patients within the Intensive Care Unit generally present with imminent risk of harm to self or others and require the highest level of supervision to maintain safety. Patients on this unit will be those who are unable to reliably contract for safety. Staffing at this level of care will maintain a minimum of 3:1 patient to staff ratio with the ability to 1:1 as necessary.

The table below represents the minimum staffing pattern for nursing and total direct care for each unit of the proposed program. This level of staffing does not include patients who are on 1:1 supervision. The table indicates the minimum number of nursing staff and the total number of staff on each shift for each level of care.

Core Staffing Levels						
Unit / Bed Capacity	**Day**		**Evening**		**Night**	
	Nursing	**All**	**Nursing**	**All**	**Nursing**	**All**
General / 8	1	2	1	2	1	2
Secure / 14	2	5	2	5	2	4
ICU / 6	1	3	1	3	1	2
Total Unit	4	10	4	10	4	8

The staffing in the proposed program at Rutland Regional maintains the current staff to patient ratios of the existing unit for the General and Secure levels of care and creates a staffing intensity for the Intensive level consistent with the Brooks I and Brooks II units of the current Vermont State Hospital.

It is important to note that Rutland Regional would like to continue to review and refine the details of this staffing with DMH to ensure all parties are satisfied with the levels.

Staff Worked Hours / Bed Day					
	Rutland Regional Proposed				**VSH [a]**
	Total	**General**	**Secure**	**ICU**	**Brooks I & II**
Bed Capacity	28.00	8.00	14.00	6.00	40.00
Average Daily Census	25.00	6.00	13.00	6.00	36.00
Worked Hrs/Bed Day	10.33	8.53	9.12	14.74	14.61
Pt:Staff	1.94	2.35	2.20	1.36	1.64

[a] The estimates for VSH are based on data provided in the RFP which describes for core staffing plus an average of eleven 1:1 patients per day.

A. Capacity to admit 24-7 and 365 days/year.

Physician, nurse and support staffing will be maintained at a level to ensure that there is capacity to admit patients 24 hours a day, 365 days a year. The program will be staffed by psychiatry staff 24 hours a day. Only patients meeting acute care criteria will be admitted to the unit.

B. Provision of emergency involuntary procedures 24-7 and 365 days/year with psychiatrist on-site within one hour to assess the patient.

Rutland Regional will continue its policy that requires a physician to directly assess any patient within one hour of any emergency procedure. Moreover, staffing levels of RNs will be maintained at a level sufficient to provide for nursing assessment of patients in seclusion or restraint in accordance with the Rutland Regional Policy on Restraint and Seclusion. This policy requires that patients in seclusion or restraint remain in continuous direct observation with an assessment by a RN at least every hour.

C. Capability to staff patients one-to-one or two-to-one to safely manage acuity and unit milieu.

Based on data provided by DMH regarding the frequency of patients requiring 1:1 supervision, the current proposed staff plan anticipates that 25% in the ICU will require this level of supervision. Additionally, management will actively maintain a list of qualified and trained per diem staff to provide additional 1:1 coverage to meet peak demand including the possibility that all six patients within the ICU may require the 1:1 supervision. Also included in the present proposal is an increase in Hospital security staff who are available to provide back up for unit staff 24 hours a day.

D. Nursing and staff ratios consistent with the provision of the most acute psychiatric care. In addition, staff is required to transport patients to court hearings and for visits to discharge placements and intake appointments.

The proposed staffing model includes a limited ability to accompany patients to offsite appointments or meetings. It is our intent to continue to work with DMH to develop systems that minimize the need for this capacity. For example, many other states have developed the ability to provide court hearings within hospitals. Additionally, systems being developed by DMH through the Care Management System planning process may significantly impact this piece of staffing. For example, it is unclear what levels of care will be available in which parts of the State. Rutland Regional will work closely with each of the Community Mental Health Centers to facilitate patient participation in all clinically appropriate planning meetings.

E. Medical evaluation and treatment services.

The proposed program will be fully integrated into the main hospital systems and have full access to all the medical services and facilities offered by Rutland Regional Medical Center. This connectedness between the psychiatric unit and other medical units is fully implemented within the current systems at Rutland Regional and will continue under the proposed program. Patients with emergent, urgent and co-existing medical conditions are attended to as anywhere else in the hospital. All patients will be medically evaluated as part of the admission process and then evaluated daily by an attending psychiatrist. Based on the physician assessment, consultation can be ordered to address both urgent and routine medical needs of patients. In addition, the program will participate in the hospital wide Rapid Response Team which provides a multidisciplinary response within minutes to non-ICU patients. The Rapid Response Team (RRT) assesses, treats, and stabilizes a patient whose condition is deteriorating. The RRT also educates and supports staff nurses, assists with physician communication, and transfers patients, if necessary. For patients whose medical needs require transfer from the Psychiatric Unit, supervision of the patient will be provided by a combination of staff from medical units, the psychiatric unit, and security.

F. Recovery and psycho-social programming designed to treat patients with treatment refractory mental illness, patients with a slow response to medical and psychosocial interventions, patients who are involuntary and who may be extremely reluctant to engage in recovery, and patients with complex co-occurring conditions (for instance developmental delay, head injury, dementia, and substance use).

Rutland Regional has significant experience providing treatment to a diverse array of patients with varied clinical presentations. Approximately 20% of the patients currently served by the psychiatric services at Rutland Regional are on involuntary status for some portion of their stay. While hospitalization may be mandated in these cases, specific treatment is not. Patients are encouraged to participate in the groups and milieu activities, but never mandated or coerced. Groups and milieu activities are flexible and responsive to needs of patients. For example, while some patients may be unwilling to participate in group psychotherapy, they may be willing to participate in a crafts group lead by an occupational therapist. The focus of treatment for patients unwilling to engage in traditional therapies is on developing the patient's ability to trust staff and feel safe while in the hospital. Individual therapy and activities are provided on a daily basis for patients who are unwilling or unable to participate in the larger group.

Within the proposed program there will frequently be multiple groups/activities occurring at the same time within the unit. Patients will be encouraged to choose groups and activities that are most appropriate for their needs and preferences. Programming will take reflect the perspective that people with mental health issues can have hope, control over their lives, develop self-directed wellness plans, and recover, working toward meeting their own life dreams and goals.

Staffing for these programs is included in this proposal.

G. Capacity to develop complex discharge plans requiring extensive knowledge of the community mental health system and long term care system.

Rutland Regional has substantial experience in discharge planning across the State. Currently, fully 50% of patients admitted to our current psychiatric unit come from outside Rutland County. We work closely with CRT programs, all levels of nursing homes, outpatient mental health providers, primary care physicians, other community resources to develop step down plans for patients with complex needs. Patients themselves, along with their families and other members of their support networks are always at the center of our discharge planning efforts, focusing on implementing plans they have helped develop.

H. Capacity to interface with the ongoing system of care to insure bed availability for the next most acute admission.

The proposed program will work closely with DMH and other partners to coordinate admissions into the program and to facilitate appropriate discharges to lower levels of care. The ability of the program to accept new admissions is directly connected to our ability to arrange clinically appropriate step down for patients. Unit leadership will actively participate in the Care Management System being developed by DMH in order maximize patient flow through the system of care. The key contacts for Rutland Regional in interacting with DMH and other providers will be our program and medical directors.

Our ability to accept new patients will be limited by the following factors:

1. Overall licensed capacity. The program will admit patients up to the licensed capacity of the program which we anticipate to be 28 beds. We will work closely with DMH and other entities still in development to manage the acute care needs of patients.
2. Availability of a bed within an appropriate level of care. Rutland Regional will strive to stabilize patients such that they will transition from higher to lower levels of treatment (i.e., Intensive to Secure and Secure to General). However, in rare circumstances a patient requiring a higher level of care may be denied admission even though there are beds available at a lower level of care. For example, if a patient requiring an intensive level of service is presented for admission when there are six existing ICU patients with none appropriate for step down to the secure level due to the risk they pose to other patients, the new admission would be denied.

I. Capacity to interface regularly with the DMH legal unit and the Mental Health Law Project. Lead the clinical preparation for legal procedures (hospitalization / commitment hearings, applications for involuntary treatment, applications for non-emergency involuntary medication, development of orders of non-hospitalization). Provide psychiatrist testimony at hearings.

In our role as a Designated Hospital we maintain a close working relationship with the DMH legal unit. Rutland Regional has substantial experience with preparing for commitment hearings, participating in development of applications for involuntary treatment, development of orders on non-hospitalization, and providing testimony at hearings. Applications for non-

emergency involuntary mediation represents a new aspect of care for which we will look to the DMH Legal Unit to provide education and training for our physicians and unit leadership.

Describe your organization's ability to recruit and staff this type of specialty programming and any proposed strategies to assure successful recruitment and retention.

The scope of this new program will more than double the size of our current staff within psychiatric services. It has been our experience over the past two years that strong unit leadership is key to all recruitment efforts. In the past two years Rutland Regional Psychiatric Services has had substantial recruitment success for all positions, including nursing. In each case of turnover we have had multiple qualified applicants and have not utilized "travelers" in over two years. Nevertheless, we do recognize the difficulty in hiring so many staff at one time. Strategies we anticipate using

Nursing Preceptor Program. Psychiatric Services has developed a 13-week preceptor program for nurses who have recently graduated. This program provides a comprehensive training program in all phases of psychiatric nursing. At the end of the preceptor program, participants are ready to assume

Aggressive Recruitment. Through targeted advertising, direct solicitation, and financial incentives (e.g., signing bonuses and moving expense reimbursement.) we expect to be able to maintain a steady flow of qualified applicants.

Solicitation of Experienced VSH Staff. We recognize the value of the experience represented within the current workforce at VSH. We will make efforts to work with DMH, VSH staff and the VSEA to ensure that qualified VSH staff provided opportunities to apply for new positions at Rutland Regional.

Connecting to Training Programs. For hard to fill positions such as Occupation and Recreational Therapists, we will continue our connection to training programs that have allowed us to function as an internship site. Additionally, we will work with local colleges to facilitate supervised training experiences and to develop a cadre of qualified psych techs.

Please provide a proposed staffing roster by discipline, role, and shift expressed in "Full Time Equivalent" (FTEs).

Staffing Roster			
Unit	**Title**	**Shift**	**fte**
Secure	Clinical Psychologist Total	1	0.50
	MSW Total	1	3.00
	Occupational Therapist Total	1	1.00
	Recreational Therapist Total	1	0.50
	RN Total	1	3.35
	LPN Total	1	2.10
	Psychiatric Tech Total	2	1.56
	RN Total	2	3.98
	Psychiatric Tech Total	3	3.14
	RN Total	3	5.76
Intensive	Clinical Psychologist Total	1	0.25
	LNA Total	1	1.05
	MSW Total	1	1.00

	Occupational Therapist Total	1	0.50
	Psychiatric Tech Total	1	0.79
	Recreational Therapist Total	1	0.25
	RN Total	1	3.67
	Psychiatric Tech Total	2	2.10
	RN Total	2	5.04
	Psychiatric Tech Total	3	2.10
	RN Total	3	1.57
General	Clinical Psychologist Total	1	0.25
	Occupational Therapist Total	1	0.50
	Recreational Therapist Total	1	0.25
	RN Total	1	2.39
	MSW Total	1	1.00
	Psychiatric Tech Total	2	1.05
	RN Total	2	1.05
	Psychiatric Tech Total	3	1.75
	RN Total	3	2.51
Admin	Admin Support Total	ALL	2.10
	Clinical Manager, Nursing Total	ALL	3.00
	Director of Nursing Total	ALL	1.00
	Supervisor, Social Work Total	ALL	1.00
	Unit Director Total	ALL	1.00
Physician	MD Total	ALL	6.46

4. LICENSURE AND GOVERNANCE

As indicated above the unit will be licensed as part of the Rutland Regional Medical Center and will be overseen by its Board of Directors. A list of the Board of Directors can be found in Attachment A.

In addition, in November 2007 Rutland Regional Psychiatric Services established a Community Advisory Committee that has met monthly since that time. Participants include patients, family members, advocates, providers and Department staff. The committee has been fully involved in the development of several key policies. The meeting agenda for these open meetings is set by consensus with opportunity at each meeting for any committee member or community member to raise issues they would like to see the committee address. Rutland Regional is committed to continuing the Community Advisory Committee as an element of this proposal.

5. PROGRAM COSTS

As noted above the initial rough estimate of construction costs in spring 2008 dollars for the 25 bed unit was $25 million.

The line item budget, staffing pattern as well as costs per day, can be found in Attachment B. This includes a comparison to the State Hospital's current costs.

6. PROGRAM REVENUES

The anticipated payer mix of the combined inpatient Psych unit is as follows:

	Gross	Net
Medicare	37.9%	38.9
Medicare-HMO	.1	.1
Medicaid	37.5	39.7
Catamount	1.3	1.6
Blue Cross-VT	6.6	8.5
Blue Cross-Out of state	1.1	1.9
MVP	1.2	2.0
CIGNA	5.1	6.1
Other commercial	.8	1.3
Self (patient responsibility)	8.4	0
Total	100%	100%

There percentages are based on the actual fiscal year to date June 30, 2009 utilization of our existing inpatient Psych unit. Our fiscal year begins on October 1st; therefore, this represents nine months of data.

The gross revenue percentages are based on our charges. The net revenue percentages are based on the amounts collected. You will note that although 8.4% of our services are provided to patients who do not have insurance, the entire amount is written off to bad debt or free care. Patients qualify for free care based on a process that determines their income compared to the Federal Poverty Limits, or based on proof that they qualify for other State assistance programs such as food stamps.

The detail of the gross revenue is as follows:

Room and Board	$4,160,611
Professional fees	513,523
Other professional fees	51,109
Ancillary services	2,332,398
Total	$16,396,721

We have categorized the revenue between Room and Board, Professional fees, Other professional fees, and Ancillary. Room and Board represents the daily rate for the nursing care, meals, depreciation expense of the building and equipment and support staff like housekeeping and security. The professional fees represent the fees charged by hospital based psychiatrists for the direct care of the patients. Other professional fees represent fees charged by physicians other than psychiatrists for consults. Ancillary revenue largely represents lab and pharmacy, but also includes all of our patient services.

The projection of the revenue is based on the June 30, 2009 year to date revenue per patient day multiplied by the 9,125 estimated patient days based on an average daily census of 25.

We do not anticipate any barriers to realizing revenues projected in this pro-forma financial statement. Rutland Regional is currently a Medicare Dependent Hospital which means that we have at least 60% of our revenue from Medicare. This entitles us to additional reimbursement from Medicare. Effective 10/01/2009, we will become a Sole Community Hospital which has additional reimbursement advantages. There are no regulatory limitations as to the number of

beds that a Sole Community Hospital can have. For 2010, we have budgeted an average daily census of 76.2 patients per day, excluding both Psych and Rehab.

7. IMPACT ON THE HOST ORGANIZATION

As described above the average daily census of psychiatric patients is expected to double from 12.5 to 25. It is not expected that this program will have impact on other operations at Rutland Regional. The key to the program being sustained is sufficient, ongoing operational funding from the State of Vermont.

8. FINANCIAL STATEMENTS

They are found in Attachment C.

9. COLLABORATION PRINCIPLES BETWEEN THE STATE OF VERMONT AND RUTLAND REGIONAL MEDICAL CENTER

Rutland Regional agrees with all of the collaboration principles detailed in the State's Request for Proposals dated June 29, 2009, with one exception and one comment. First the exception, the Fiscal Principles (p23 -24) were deemed by the State and Rutland Regional not to be feasible last fall. The alternate funding mechanism is described above. A proposal for operating funding is being drafted by the State. As to the comment, admissions to the unit could be impacted by the physical capacity of the unit as described in Section 3 above.

Conclusion: Rutland Regional strongly believes that alternatives to the Vermont State Hospital in Waterbury must be found. We believe we can play a key role in this effort. Central to the success of this effort is having a sustainable funding source from the State of Vermont. If that can be achieved we believe financing is possible, construction of the facility is possible and the care of these patients can be taken on at the Rutland site. Importantly, this care would be eligible for Federal reimbursement through the Medicare and Medicaid programs without the use of waivers. Rutland Regional looks forward to the challenge.

RRHS/RRMC Board of Directors

ATTACHMENT A

2009 – 2010

2010***	J. Christian Higgins, MD	Champlain Valley Cardiovascular Associates 1 Commons Street Rutland, VT 05701	773-5745
2010**	Mark K. Foley	P.O. Box 99 Rutland, VT 05702	775-5003 X11
2010*	Michael McCormack	66 Grove Street Rutland, VT 05701	775-3221
2011	Joseph Giancola	140 Granger Street Rutland, VT 05701	773-6251
2011*	Mary E. Moran	6 Church Street Rutland, VT 05701	786-1998
2011**	Jessica L. Anderson	UBS P.O. Box 600 Rutland, VT 05702	772-3250
2011	Victoria P. Young	36 Oak Street Proctor, VT 05765	459-3336
2011***	Bill Bannerman	2586 West Hill Road Wallingford, VT 05773	446-3560
2012*	Gordon H. Chader	P.O. Box 426 Bomoseen, VT 05732	468-0011
2012*	Matthew A. Conway, MD	Rutland Regional General Surgery 241 Stratton Road Rutland, VT 05701	775-1903
2012*	Joan F. Gamble	CVPS 77 Grove Street Rutland, VT 05701	747-5730
2012*	Jon S. Readnour, Esq.	Readnour Associates, P.C. 26 West Street, Suite 3 Rutland, VT 05701	773-7108
FAHC Representative	John R. Brumsted, MD	FAHC Patrick 212 111 Colchester Avenue Burlington, VT 05401	847-9795
Dartmouth-Hitchcock Representative	John C. Collins	Dartmouth Hitchcock One Medical Center Drive Lebanon, NH 03756-0001	(603)650-5326
President Medical Staff	Richard D. Lovett, MD	RRMC Community Cancer Center	747-1831
Vice President Medical Staff	Kirk Dufty, MD	RRMC Emergency Dept.	747-6216
RAVNAH Representative	Ron J. Cioffi	RAVNAH P.O. Box 787 Rutland, VT 05702-787	770-1544
Advisory Staff Members:	Sarah Donaldson Joan Spaulding, RN		

RRHS / RRMC Officers: Victoria P. Young, Chair
Jon S. Readnour, Esq., Vice Chair
Jessica L. Anderson, Secretary

*** Eligible for three additional three-year terms
** Eligible for two additional three-year terms.
* Eligible for one additional three-year term.

July 2009

ATTACHMENT B

Rutland Regional Medical Center Program Costs

	Total Cost	Patient Days	Cost/Day
State Cost Per Day	$23,315,960	16,425	$ 1,420
RRMC Cost Per Day - total	$14,316,618	9,125	$ 1,569
RRMC Loss Per Day - total	$ 4,166,509	9,125	$ 457

>The total cost per day for the State to operate the State Hospital is $1,420 per their Budget for 2010 based on an average daily census of 45

>The RRMC total cost per day to operate the combined unit is $1,569. Included in this cost is $226 for depreciation and interest which we do not believe is included in the State expense. The cost net of depreciation and interest is $1,343

>The RRMC net cost per day (cost less reimbursement for services) to operate the combined unit is $457

>The difference between the RRMC net cost per day to operate the expanded unit of $457 and the State cost per day of $1,420 is $963 or 68% less than the State cost per day

>This net cost represents the overall net loss of the combined Psych unit (after consideration of all other revenue sources) which RRMC would then be reimbursed through the Operating Agreement.

>The estimated annual savings to the State for RRMC to manage these 12.5 average patients per day at $457 vs. the State at $1420 would be $4.39 million (($1420-$457)x12.5x365)

>We have assumed an overall average acuity based on a mix of patients of the type currently cared for in the RRMC inpatient Psych unit and patients currently being cared for by the State. If the acuity increases more than expected, then there would be a corresponding increase in cost

>We have also assumed that the same percentage of the revenue currently collected by RRMC for its inpatient Psych unit will be collected for the patients formerly cared for by the State.

>Our assumption is that all losses associated with this combined program will be reimbursed under the Operating Agreement through a cost sharing arrangement with the Federal Government under the global commitment

>Incremental overhead expenses include Maintenance and Operation of Plant, Laundry, Housekeeping, Dietary, Administrative and General including Human Resources and Medical Records

>We have not included the overhead expense for our current Psych unit

>Interest expense is based on $25 million of debt with a 5.5% interest rate for 20 years

>Depreciation expense is based on $25 million building and equipment cost with an average 20 year useful life

>We have included 3.2 FTEs of additional Security personnel

RRMC
Inpatient Psych Analysis - Includes Physicians
Revised 7/29/09

ATTACHMENT B

	2010 @ ADC of 12.5			2010 @ Additional ADC of 12.5			2009 @ ADC of 25.0			
	I/P Unit	Physicians	Total	I/P Unit	Physicians	Total	I/P Unit	Physicians	Total	Check
Gross revenue	$ 7,536,272	$ 662,089	$ 8,198,360	$ 7,536,272	$ 662,089	$ 8,198,360	$ 15,072,543	$ 1,324,178	$ 16,396,721	$ -
Less: contractual allowances	$ (2,801,715)	$ (321,591)	$ (3,123,306)	$ (2,801,715)	$ (321,591)	$ (3,123,306)	$ (5,603,430)	$ (643,182)	$ (6,246,612)	$ -
										$ -
Net revenue	$ 4,734,557	$ 340,498	$ 5,075,054	$ 4,734,557	$ 340,498	$ 5,075,054	$ 9,469,113	$ 680,996	$ 10,150,109	$ -
										$ -
Expenses:										$ -
Salaries (used 2010 sal/2010 FTEs adjusted for 4563 pt days)	$ 1,475,571	$ 435,187	$ 1,910,758	$ 2,041,794	$ 1,037,998	$ 3,079,793	$ 3,517,365	$ 1,473,185	$ 4,990,550	$ -
Fringe Benefits (used 34.22% 2010 fringe benefit %)	$ 504,940	$ 148,921	$ 653,861	$ 698,702	$ 355,203	$ 1,053,905	$ 1,203,642	$ 504,124	$ 1,707,766	$ -
Supplies (includes temp staffing dollars)	$ 895,967	$ 13,511	$ 909,478	$ 1,696,016	$ 36,899	$ 1,732,914	$ 2,591,982	$ 50,410	$ 2,642,392	$ -
Bad Debt Expense	$ 629,526	$ 58,182	$ 687,708	$ 629,526	$ 58,182	$ 687,708	$ 1,259,052	$ 116,364	$ 1,375,416	$ -
Interest Expense (Average for 20 yrs) **(2)**	$ -	$ -	$ -	**$ 813,662**	$ -	$ 813,662	**$ 813,662**	$ -	$ 813,662	$ (0)
Depreciation Expense (Based on 20 year Life) **(3)**	$ -	$ -	$ -	**$ 1,250,000**	$ -	$ 1,250,000	**$ 1,250,000**	$ -	$ 1,250,000	$ -
Incremental Overhead Expenses **(1)**	$ -	$ -	$ -	**$ 1,422,048**	$ -	$ 1,422,048	**$ 1,422,048**	$ -	$ 1,422,048	$ -
Salaries - Security (Including Fringe Benefits) **(4)**	$ -	$ -	$ -	$ 114,784	$ -	$ 114,784	$ 114,784	$ -	$ 114,784	$ -
										$ -
Total Expenses	$ 3,506,003	$ 655,801	$ 4,161,804	$ 8,666,532	$ 1,488,282	$ 10,154,814	$ 12,172,535	$ 2,144,083	$ 14,316,618	$ (0)
										$ -
Net Profit (Loss)	$ 1,228,553	$ (315,303)	$ 913,250	$ (3,931,975)	$ (1,147,784)	$ (5,079,759)	$ (2,703,422)	$ (1,463,087)	$ (4,166,509)	$ 0
										$ -
Net to Gross Percentage	62.8%	51.4%	61.9%	62.8%	51.4%	61.9%	62.8%	51.4%	61.9%	$ 1
Net to Gross Percentage (Including Bad Debt)	54.5%	42.6%	53.5%	54.5%	42.6%	53.5%	54.5%	42.6%	53.5%	$ 1
										$ -
Patient Days	4,563	4,563	4,563	4,563	4,563	4,563	9,125	9,125	9,125	$ -
Net Revenue (excl. Bad Debt) Per Patient Day	$ 1,038	$ 75	$ 1,112	$ 1,038	$ 75	$ 1,112	$ 1,038	$ 75	$ 1,112	
Net Revenue (incl. Bad Debt) Per Patient Day	$ 900	$ 62	$ 962	$ 900	$ 62	$ 962	$ 900	$ 62	$ 962	
Net Revenue (inc. Bad Debt) Per Patient Day Required to Break Even	$ 630	$ 131	$ 761	$ 1,762	$ 313	$ 2,075	$ 1,196	$ 222	$ 1,418	
Physician/Psychologist FTEs - PSIU	0.00	2.00	2.00	0.00	5.46	5.46	0.00	7.46	7.46	0
Non Physician FTEs - PSIU	22.59	0.00	22.59	39.40	0.00	39.40	61.99	0.00	61.99	0
Temporary Staffing - PSIU	1.83	0.00	1.83	1.68	0.00	1.68	3.51	0.00	3.51	0
Total FTEs	24.42	2.00	26.42	41.08	5.46	46.55	65.50	7.46	72.97	0

(1) Incremental Overhead Expenses includes Maintenance and Operation of Plant, Laundry, Housekeeping, Dietary, and Administrative and General including Human Resources and Medical Records.
(2) Interest Expense is based on $25 million of debt with a 5.5% interest rate for 20 years
(3) Depreciation Expense is based on $25 million with a 20 year useful life
(4) Represents 3.2 FTEs

Notes:

Operating agreement must be designed to support overall costs

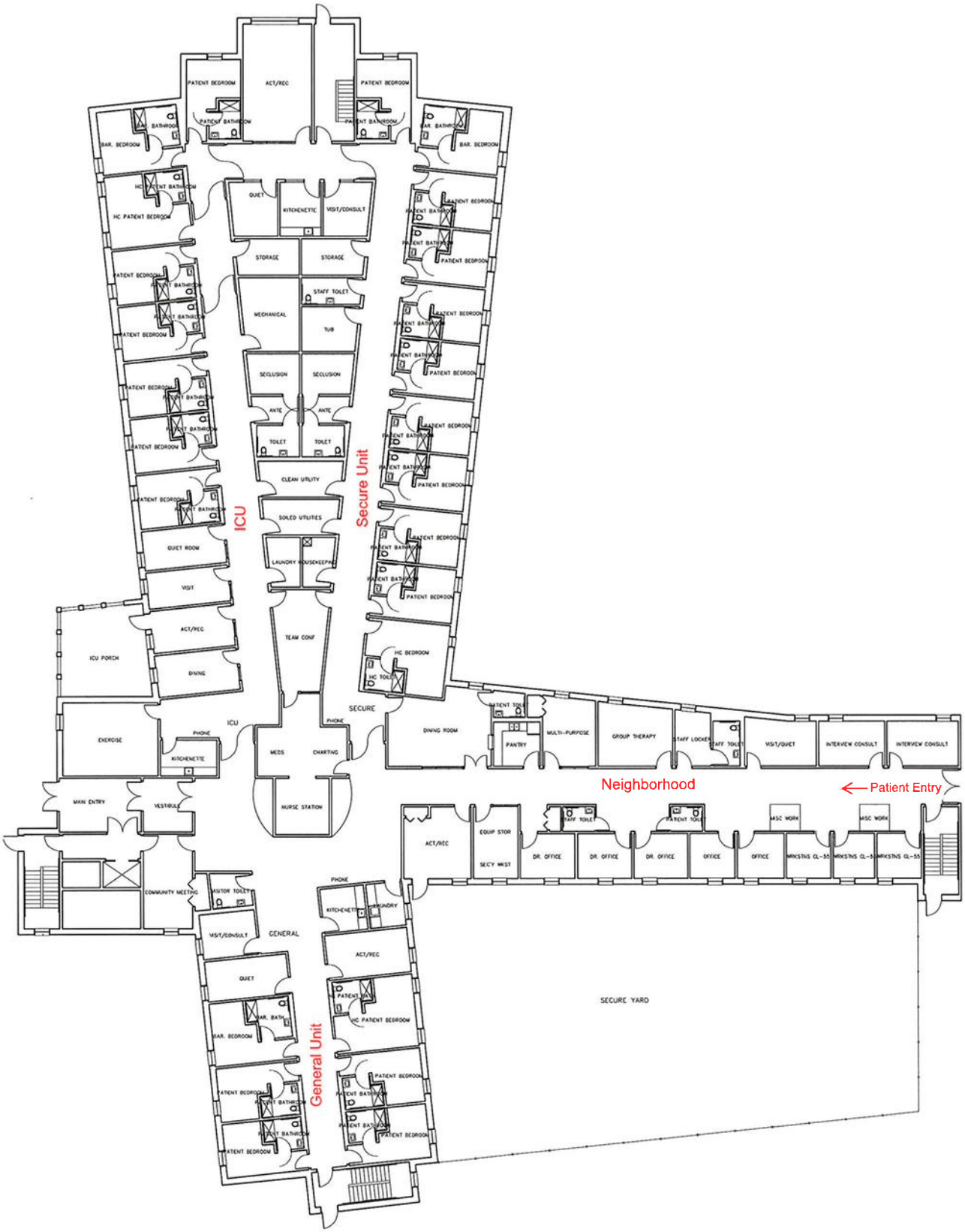
Bad Debt Expense: Based on June 2009 FYTD Payor Mix: Self Pay = 8%

Payer Mix IP Psych Unit FYTD 6/30/09: Medicare- 38%, Medicaid- 39%, BCBS- 8%, Commercial- 7%, Self Pay- 8%

Psych IP Unit
FTE Analysis
Per Jeff McKee Analysis

ATTACHMENT B

FTE Class	Description	Staffing for 25 patients/day census	FY 2010 Avg Salary By Class	Total Salaries	
1	Nursing Aides	1.05	$ 31,750	$ 33,274	*No Class 1 in current budget so used Class 3 avg
2	Nursing - Clerical	2.10	$ 36,749	$ 77,173	
3	Clerical		$ 31,750	$ -	
4	LPN	2.10	$ 37,375	$ 78,338	
5	Non-Professional Tech	12.73	$ 36,749	$ 467,815	*No Class 5 in current budget so used Class 2 avg
6	Environmental	-	$ -	$ -	
7	RN	25.82	$ 73,671	$ 1,902,185	
8	Management	2.00	$ 91,446	$ 182,892	
9	Nurse Management	4.00	$ 91,446	$ 365,784	
10	Physicians	7.46	$ 197,425	$ 1,473,185	
11	Professional Tech	9.00	$ 49,242	$ 443,178	
12	Midlevel/NP Providers			$ -	
14	Orientation	-		$ -	
Total FTE's Excluding Temp Staffing		**66.26**		**$ 4,990,550**	
Temporary Staffing (all RN's)		3.51		**$ 475,830**	used $65/hour for temporary staffing
Total FTE's Including Temp Staffing		**69.77**		**$ 5,466,380**	
Security FTE's (Class 6)		3.20	$ 34,683	$ 110,986	
Total FTE's Inc Temp Staffing & Security		**72.97**		**$ 5,577,365**	



DRAFT - For Discussion Purposes Only

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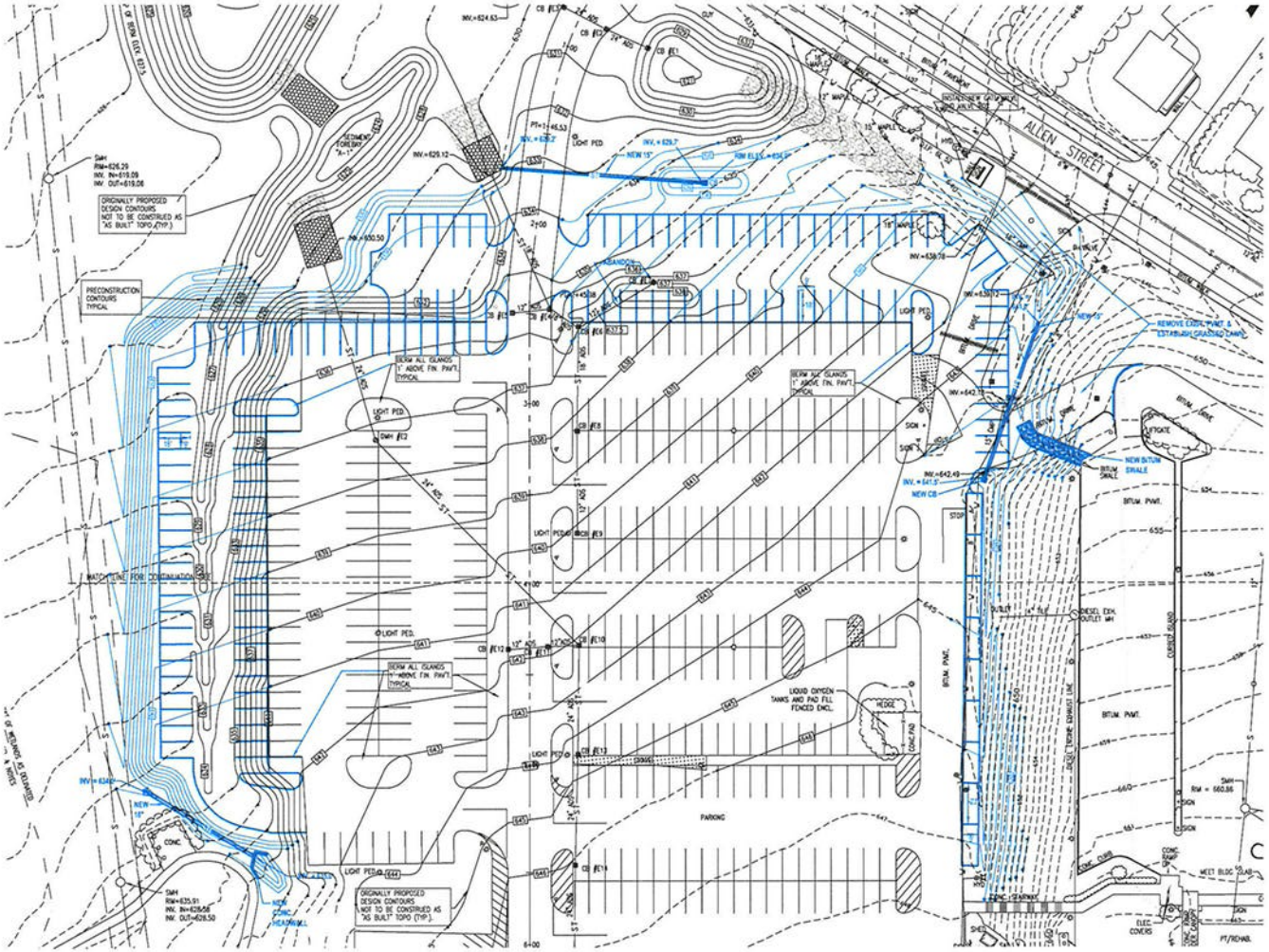
STATE OF VERMONT DMH – FUTURES PROJECT

FLOOR PLAN – 25 BED PSYCHIATRIC UNIT @ RUTLAND REGIONAL MEDICAL CENTER

architecture



Note: The base mapping used to prepare this plan sheet was supplied as a courtesy by Engineering Ventures, Inc. (EV) of Burlington, Vermont. Information supplied by EV is shown in black. Features added by SVE Associates are shown in blue. The information supplied by EV is from design plans prepared by them for the RRMC Emergency Department Expansion (EDE) project that was constructed in 2002, and may not represent that project as-built, or the hospital campus as it now exists. All EV information shown is for reference only and its accuracy as to its relation to the EDE project as-built as well as the present day RRMC campus site condition should be verified.

REV.	DESCRIPTION	BY	DATE

CIVIL ENGINEER

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DATE: APRIL 8, 2008
PROJ. NO.: R1235
DRAWN BY: M. H. ROBERTS
SCALE: 1" = 30 FT.
SHEET 1 OF 1